DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 2 2

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 through 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 66.4 million
b. FFY 2002 $ 77.7 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages ~~1-20~~ 1-15.1 and 17-22.
pso gm

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, pages ~~1-22~~ 1-15 and 17-20.
pso gm

10. SUBJECT OF AMENDMENT:
Long Term Care Rates

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's office does not wish to review State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gail Margolis

14. TITLE:
Deputy Director

15. DATE SUBMITTED:
September 28, 2001

16. RETURN TO:
Department of Health Services
Attn: State Plan Coordinator
714 P Street, Room 1601
Sacramento, CA 95814

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 28, 2001

18. DATE APPROVED:
November 29, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator
Division of Medicaid

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT FOR ALL CATEGORIES OF NURSING FACILITIES AND

INTERMEDIATE CARE FACILITIES FOR THE DEVELOPMENTALLY DISABLED

The purpose of this State Plan is to (1) establish the principles of the State of California's reimbursement system for providers of long-term care services to assure compliance with the requirements of Title XIX of the Federal Social Security Act and the Code of Federal Regulations, and (2) describe the procedures to be followed by the single state agency, the Department of Health Services (herein called the Department), in determining long-term care reimbursement rates.

I. GENERAL PROVISIONS

A. The State shall set prospective rates for services by various classes of facilities, including special programs.

B. Reimbursement shall be for routine per diem services, exclusive of ancillary services, except for state-owned facilities where an ancillary per diem rate shall be developed by another state agency, and for county facilities operating under a special agreement with the Department. These ancillary rates are reviewed and audited by the Department and, together with the routine service per diem, form an all-inclusive rate. The routine service per diem shall be based on Medicare principles of reimbursement. Ancillary services for all other facilities are reimbursed separately on a fee for service basis as defined in the California Code of Regulations (CCR), except for facilities providing subacute, pediatric subacute and transitional inpatient care services.

C. The routine service per diem includes all equipment, supplies and services necessary to provide appropriate nursing care to long-term care patients or intermediate care for the developmentally disabled, except those items listed as separately payable or personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility as part of patient care and periodic hair cuts), and television rental.

D. Not included in the payment rate and to be billed separately by the provider thereof,

subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are:

1. Allied health services ordered by the attending physician, excluding respiratory therapy.
2. Alternating pressure mattresses/pads with motor.
3. Atmospheric oxygen concentrators and enrichers and accessories.
4. Blood, plasma and substitutes.
5. Dental services.
6. Durable medical equipment as specified in Section 51321(g).
7. Insulin.
8. Intermittent positive pressure breathing equipment.
9. Intravenous trays, tubing and blood infusion sets.
10. Laboratory services.
11. Legend drugs.
12. Liquid oxygen system.
13. MacLaren or Pogon Buggy.
14. Medical supplies as specified in Section 59998.
15. Nasal cannula.
16. Osteogenesis stimulator device.
17. Oxygen (except emergency).
18. Parts and labor for repairs of durable medical equipment if originally separately payable or owned by beneficiary.
19. Physician services.
20. Portable aspirator.
21. Portable gas oxygen system and accessories.
22. Precontoured structures (VASCO-PASS, cut out foam).
23. Prescribed prosthetic and orthotic devices for exclusive use of patient.
24. Reagent testing sets.
25. Therapeutic air/fluid support systems/beds.
26. Traction equipment and accessories.
27. Variable height beds.
28. X-rays.

For subacute, pediatric subacute, and transitional levels of care, items can be separately billed as specified in Title 22 CCR, Sections 51511.5(d), 51511.6(f) and 51511.3(f) respectively (see Appendix 4).

E. The application of the methodology described in this Attachment, with the most recent update factors and constants used to project costs, is included in an annual rate study conducted by the Department prior to August 1st each year and required by the CCR as an evidentiary base for the filing of new and/or revised regulations. This annual rate study is designated as Supplement 1, and will be provided to the Centers for Medicare and Medicaid Services (CMS) by December 31st of the rate year. The rates will become effective as provided for by the State's Budget Act, typically on August 1 of each year.

F. If a freestanding facility's change in bedsize has an impact on the reimbursement rate, the lesser of the existing rate or the new rate shall prevail until the next general rate change. This is to deter a facility from changing bedsize groupings for the purpose of maximizing reimbursement.

G. Notwithstanding any other provisions of this State Plan, the reimbursement rate shall be limited to the usual charges made to the general public, not to exceed the maximum reimbursement rates set forth by this Plan.

H. Within the provisions of this Plan, the following abbreviations shall apply: NF-nursing facility; ICF/DD-intermediate care facility for the developmentally disabled; ICF/DD-H-intermediate care facility for the developmentally disabled habilitative; ICF/DD-N-intermediate care facility for the developmentally disabled nursing; STP-special treatment program; and DP-distinct part.

I. All long term care providers shall be required to be certified as qualified to participate in the Medi-Cal program and must also meet the requirements of Section 1919 of the Social Security Act. In order to assure that reimbursement takes into account the cost of compliance with statutory requirements, NFs shall be reimbursed based on the following criteria: (Refer to Table 1 for a specific list)

1. Resident acuity:

NFs shall be reimbursed based on the provision of the following services: level A; level B; subacute -- ventilator and non-ventilator dependent; pediatric subacute -- ventilator and non-ventilator dependent; and transitional inpatient care -- rehabilitative and medical. Level A services are provided to a NF resident who requires medically necessary services of relatively low intensity. Level B, subacute, pediatric subacute, and

transitional inpatient care services are provided to a NF resident who requires medically necessary services of varying degrees of higher intensity. The criteria for the acuity of NF services and staffing standards are contained in state regulations and policy manuals.

2. Organization type:

(a) Freestanding facilities.
(b) DP/NFs - A distinct part nursing facility is defined as any nursing facility (level A or B) which is licensed together with an acute care hospital.
(c) Swing-beds in rural acute care facilities.
(d) Subacute units of freestanding or distinct part NFs - A subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).
(e) Pediatric subacute units of freestanding or distinct part NFs - A pediatric subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).
(f) Transitional inpatient care units of freestanding or distinct part NFs -- A transitional inpatient care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).

3. Bedsize:

As listed below, in determining the appropriate bedsize categories for reimbursement purposes, a facility's total number of beds shall be used, irrespective of patient acuity level or licensure. A single facility licensed as a distinct part to provide two or more patient acuity levels, or a single facility that has separate licenses for different patient acuity levels, shall have the bedsize for each patient acuity level determined by total beds within the actual physical plant. The bedsize used to establish rates shall be based upon the data contained in the cost report(s) included in the rate study.

(a) NF level B...1-59, and 60+
(b) DP/NF level B...no bedsize category
(c) NF level B/subacute...no bedsize category
(d) DP/NF level B/subacute...no bedsize category
(e) NF level B/pediatric subacute...no bedsize category

(f) DP/NF level B/pediatric subacute...no bedsize category
(g) NF level A...1-99 and 100+
(h) DP/NF level A ...1-99 and 100+
(i) ICF/DD...1-59, 60+ and 60+ with a distinct part
(j) ICF/DD-H...4-6 and 7-15
(k) ICF/DD-N...4-6 and 7-15
(l) Swing-beds...no bedsize category
(m) Transitional inpatient care...no bedsize category

4. Geographical location:

(a) Freestanding NF levels A and B and DP/NF level A:
(1) Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara counties.
(2) Los Angeles county.
(3) All other counties.
(b) DP/NF level B, freestanding NF level B/subacute and pediatric subacute, DP/NF level B/subacute and pediatric subacute, transitional inpatient care, ICF/DDs, ICF/DD-Hs, and ICF/DD-Ns,...statewide.
(c) Rural swing-beds...statewide.

J. Special Treatment Program (STP)

For eligible Medi-Cal patients 65 years or older who receive services in an Institution for Mental Disease the STP patch rate will apply. This is a flat add-on rate determined to be the additional cost for facilities to perform these services. STP does not constitute a separate level of care.

II. COST REPORTING

A. All long term-care facilities participating in the Medi-Cal Program shall maintain, according to generally accepted accounting principles, the uniform accounting systems adopted by the State and shall submit cost reports in the manner approved by the State.

1. Cost reports are due to the State no later than 120 days after the close of each facility's fiscal year (150 days for facilities that are distinct parts of a hospital), in accordance with Medicare and Medi-Cal cost reporting

requirements.

2. Each facility shall retain its supporting financial and statistical records for a period of not less than three years following the date of submission of its cost report and shall make such records available upon request to authorized state or federal representatives.

3. All cost reports received by the State shall be maintained for a period of not less than five years following the date of submission of reports, in accordance with 42 CFR 433.32.

4. Cost reports for freestanding facilities shall be included in the rate study even though they may contain more or less than 12 months and/or more than one report, as long as the fiscal periods all end within the time frame specified for the universe being studied. Only cost reports accepted by the Office of Statewide Health Planning and Development (OSHPD) shall be included in the rate study.

5. For DP/NFs and subacute providers, only cost reports formally accepted by the Department with 12 or more months of DP/NF or subacute costs shall be used in the rate study to determine the median facility rate. For purposes of the median determination, only DP/NFs with Medi-Cal patient days accounting for 20 percent or more of their total patient days shall be included.

6. The State reserves the right to exclude any cost report or portion thereof that it deems to be inaccurate, incomplete or unrepresentative.

7. Freestanding STP facilities are excluded from the determination of freestanding NF rates due to their different staffing requirements and the complexity of their reporting costs by level of care and services. The cost reports for these facilities often comingle the data related to NF, Short-Doyle and special county programs.

8. NF Level A rates shall be established on the basis of costs reported by facilities that only provided that level of care during the cost report period.

9. The universe of facilities used to establish the prospective freestanding rates shall be provided by OSHPD on hard copy and tapes. In the case that an error

or oversight is discovered or brought to the State's attention, which would create an inequity, the Department would adjust rates in the following year to compensate providers for the error. Such an adjustment would normally be in the form of an add-on. (See paragraph IV.C, below.)

10. Where identified, facilities that have switched their level of care (e.g., ICF/DD to NF Level B) will not be used to establish rates if their cost report does not reflect their current status.

11. Where identified, facilities that have terminated from the program will be excluded from the rate studies.

12. When ICF/DD-H and N providers erroneously report calendar days instead of patient days on their cost reports, the State will contact the provider for the correct information to be used in the rate study.

B. The Department shall determine reasonable allowable costs based on Medicare reimbursement principles as specified in 42 Code of Federal Regulations (CFR) Part 413. The exceptions to this provision are:

1. The Deficit Reduction Act of 1984 (DEFRA) requires the Department to recognize depreciation only once for reimbursement purposes when a change of ownership has occurred after July 18, 1984. Since the Department reimburses long term care providers using a prospective rate methodology, the Department shall use the net book value approach in lieu of recapturing depreciation to ensure that depreciation is recognized only once for reimbursement purposes. The net book value approach is defined as follows:

   Net book value means that when a change of ownership occurs after July 18, 1984, the asset sold shall have a depreciable basis to the new owner that is the lesser of the: acquisition cost of the new owner; or historical cost of the owner of record as of July 18, 1984, less accumulated depreciation to the date of sale (or in the case of an asset not in existence as of July 18, 1984, the acquisition cost less accumulated depreciation to the date of sale of the first owner of record after July 18, 1984).

2. For developmentally disabled and psychiatric patients in state owned facilities, appropriate personal clothing in lieu of institutional gowns or pajamas are an allowable cost.

3. For purposes of determining reasonable compensation of facility administrators, pursuant to Chapter 9 of the CMS Provider Reimbursement Manual (HIM 15) – reproduced in full at Paragraph 5577 of the CCH Medicare and Medicaid Guide, the State shall conduct its own survey. Based on the data collected from such surveys, the State shall develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those facilities.

   For purposes of this section, "facilities" are defined as: acute care, long term care (skilled nursing, intermediate care, intermediate care for the developmentally disabled, intermediate care for the developmentally disabled habilitative and nursing), Federally Qualified Health Centers, and Rural Health Clinics.

III. AUDITS

A. Except for DP/NFs, subacute, pediatric subacute, transitional inpatient care units, NF-As, ICF/DDs and state-operated facilities, a minimum of 15 percent of cost reports will be field audited by the Department each year. Facilities identified for audit shall be selected on a random sample basis, except where the entire universe of a class is selected for audit. Field audits may be restricted to facilities that have a complete year of reporting. The sample size for each shall be sufficiently large to reasonably expect, with 90 percent confidence, that it will produce a sample audit ratio which varies from the estimated class population audit ratio by not more than two percent. Other facilities may be audited as necessary to ensure program integrity. The results of federal audits, where reported to the State, may also be applied in determining the audit adjustment for the ongoing rate study.

B. The labor data reported by providers shall be audited. In the event that facilities are inconsistently reporting their labor costs in the OSHPD data, the Department will adjust the data utilized to develop the labor index so that the correct amount will be reflected. If the labor data used in developing the labor index is adjusted, the State Plan will be amended to provide the specific methodology for such adjustments.

C. Reports of audits shall be retained by the State for a period of not less than five years, in accordance with 42 CFR 433.32.

D. Providers will have the right to appeal findings which result in an adjustment to program reimbursement or reimbursement rates. Specific appeal procedures are contained in Section 14171 of the Welfare and Institutions Code, and Article 1.5 (Provider Audit Appeals) of Title 22, California Code of Regulations. See Appendix 2.

E. When facilities being audited have more than one cost report with an end date in the audit year, the last report will be the one audited, except in those cases where a facility-specific audit adjustment will be applied or actual audited costs are used. In these cases, all cost reports with an end date in the audit year will be audited.

F. All state-operated facilities will be subject to annual audits.

G. Cost reports for nursing facilities that are distinct parts of acute care hospitals may be audited annually.

H. All subacute and pediatric subacute providers will be subject to annual audits.

I. All transitional inpatient care units may be subject to annual audits.

IV. PRIMARY REIMBURSEMENT RATE METHODOLOGY

Reimbursement rates shall be reviewed by the Department at least annually. Prospective rates for each class shall be developed on the basis of cost reports submitted by facilities. The following method shall be used to determine rates of reimbursement for a class of facilities when cost reports are available:

A. Audit Adjustment.

1. An audit adjustment shall be determined for each of the following classes:

(a) NF level B field audited facilities with 1-59 beds.
(b) NF level A field audited facilities with 1-99 beds.
(c) NF level B field audited facilities with 60+ beds.
(d) NF level A field audited facilities with 100+ beds.
(e) ICF/DD field audited facilities with 1-59 beds.
(f) ICF/DD field audited facilities with 60+ beds.

(g) ICF/DD-H field audited facilities with combined bedsizes.
(h) ICF/DD-N field audited facilities with combined bedsizes.

2. Except for DP/NFs and subacute providers, where the audit sample exceeds 80 percent of the universe in a class, the audit adjustment will be applied on a facility-specific basis except that the: (1) class average will be used for unaudited facilities and (2) actual audited costs will be used when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study.

3. For DP/NFs and subacute providers, actual audited costs will be used to determine the facility's prospective rate when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study. If the field audit of the cost report used in the study is not available by July 1, then an interim rate shall be established by applying the field audit adjustment of the NF level Bs with 60+ beds to the cost report. If a facility has an interim reimbursement rate, when the audit report that matches the cost report is issued or the cost report is deemed true and correct under W&I Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to the beginning of the rate year to reflect these costs, not to exceed the maximum rate as set forth in Section IV.E. Interest shall accrue and be payable on any underpayments or overpayments resulting from such adjustment. Medicare standards and principles of cost reimbursement shall be applied when auditing DP/NFs (see 42 CFR Part 413).

4. As a result of the appeal process mentioned in III.D., some audit findings may be revised. Except for DP/NFs and subacute, the audit adjustment for the current year shall incorporate any revisions resulting from a decision on an audit appeal. The Department shall consider only the findings of audit appeal reports that are issued more than 180 days prior to the beginning of the new rate year.

For DP/NFs or subacute providers, excluding pediatric subacute, that obtain an audit appeal decision that the facility-specific audit adjustment on which a DP/NF or subacute rate is based inaccurately reflects the facility's projected costs, the facility shall be entitled to seek a retroactive adjustment in their prospective reimbursement rate, not to exceed the maximum DP/NF or subacute rate, as set forth under Section IV (E)(1), (10) and (11).

5. Audited costs will be modified by a factor reflecting share-of-cost overpayments in the case of class audit adjustments.

6. The results of federal audits, when reported to the state, may be applied in determining audit adjustments.

B. Adjustment for facilities which provide a different type of service from the remainder of the class.

Additional amounts, where appropriate, shall be added to the payment rates of individual facilities in a class to reimburse the costs of meeting requirements of state or federal laws or regulations including the costs of special programs.

C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal laws and regulations which would impact upon such costs. These adjustments will be reflected as an "add-on" to the rates for these costs and, where appropriate, an "add-on" may be used to reflect other extraordinary costs experienced by providers. "Add-ons" to the rate may continue until such time as those costs are included in cost reports used to set rates under this state plan.

For example, state or federal mandates may include such costs as changes to the minimum wage or increases in nurse staffing requirements. An example of other extraordinary costs might include unexpected increases in workers compensation costs or other costs which would impact facilities' ability to continue to provide patient care.

A brief description of all add-ons included in the current year's rate study will be provided to CMS by December 31st of the rate year.

D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not